in the person of a young Russian. If the dates given in the paper are correct, the trouble began when the patient was only 10 years old, and without apparent cause. There was a neuropathic family history, but the first attack occurred on a cliff where the boy had been accustomed to go daily. While regarding the declivity, he was suddenly taken with vertigo, weakness and an agonizing oppression. With difficulty he regained the dwelling, which was near at hand, and was obliged to go to bed. The next day he could laugh at his fears and had no more attacks for a year. Then he was again seized with the unaccountable fainting terror and for the remainder of the summer was unable to walk on any elevation, even a hill. Seated in a carriage he had no trouble. Following this time he lived for six years in a flat country and was perfectly well. He then had occasion to return to the scene of his first attack when the trouble immediately returned, and was more severe than ever. He was now as bad in a carriage as on foot, and even to look out of the window of a house situated on a bluff brought on the insupportable agony with a feeling of impending death. For two years after this he was the subject of this abnormal fear. Looking at a photograph or painting of mountains would bring on an attack. He began, too, to be nervous and apprehensive in a crowd and felt comfortable only at home or on a plain. A combination of tonics and sedatives greatly improved his condition, but there is no assurance against a relapse. PATRICK (Chicago).

A STUDY OF THE BLOOD IN GENERAL PARALYSIS. By J. A. Capps. American Journal of the Medical Sciences, June 18, 1896.

The conclusions based on the observation of 19 cases are:

1. The hæmoglobin and red corpusales are always diminished.
2. The specific gravity falls slightly below the normal.
3. Most cases show a slight leucocytosis, amounting on an average to about 22 per cent. above the normal. Early cases may have no leucocytosis whatever.
4. In the differential count a decrease is found in the lymphoyts along with a marked increase in the large mononuclear cells. The essiuophiles in a few cases are very numerous.

In convulsions and apoplectiform attacks (1) the red corpuscles and hæmoglobin are usually increased at the time of a convulsion. During an apoplectic attack of long duration they are both somewhat diminished.

2. The specific gravity is variable, sometimes increasing, sometimes diminishing, at the time of an attack.
3. There is a leucocytosis after convulsions and apoplectic attacks, which is as sudden as it is usually pronounced. It certainly does not appear until within a very short time preceding the convulsion, probably not before it actually takes place.
4. The degree of leucocytosis and the period of its continuousness, as a rule, vary directly with the length and severity of the attack.
5. In the production of the leucocytosis the large mononuclar cells are increased relatively more than any other variety.
6. The fact that after convulsions and apoplectic attacks in general paralysis there is not only an increase in the number of white cells, but a change in their character, as shown by the differential count, and at times abnormal cells appear, is an argument against the theory that leucocytosis is merely a change in the distribution of the white corpuscles. SHIVELY.

DISTURBANCE OF SENSIBILITY IN MELANCHOLIA.

Dr. Pierre Dheur finds (Thése de Paris, 1896, No. 62) that disturbances of sensation are the rule in the course of melancholia, whether the form of the disease be the depressed, agitated or dull type.

There is one disturbance of sensation which is constant, viz., the loss or considerable diminution over a greater or less surface of tactile sensibility. The analgesia is often so extensive as to leave but a small portion of the surface healthy. The one area which is seldom affected Dr. Dheur finds to be the upper-lip. The analgesia is sometimes localized in a single limb, often on only one aspect of a limb; the lesions are frequently, but not always, symmetrical. Lessening of thermal sense is noted chiefly in agitated melancholia. The reflexes are also sometimes lost in these patients, and four times Dr. D. has seen the patellar reflex exaggerated. In one-third of the cases hyperæsthesia is present, usually of small extent and very variable in situation. Olfactory, gustatory and auditory sensibility are all occasionally found affected. Diminution of vision often coinciding with narrowing of the visual fields was also observed. Respiratory movements were noticed to be irregular in some cases, and often less frequent than in the healthy.

These interesting observations, like so many of the disturbances of sensibility in hysteria will probably not be found to be so usual in this country as in France. .J. K. Mitchell.

Mental Changes in Graves' Disease. By A. Mande, L.R.C.P. Jour. of Ment. Science, January, 1896.

Dr. Mande reviews twenty cases of exophthalmic goitre, studying the mental phenomena. He considers only one of the twenty as definitely insane, yet regards only two of the twenty as having normal mental state. He describes as common an irritable restless state that he calls neurasthenic, with chorea of ideas and loss of ability for connected thought. Personally, we are impressed with this description in its alliance to the irritable prodromal state of senile dementia, choreic dementia and paretic dementia.

The Disorders of the Muscular System in Insanity. Theodore H. Kellogg, M.D. Medical Record, Aug. 15, 1896.

In a timely paper on the above subject, Kellogg points out the various disorders manifested in the muscular apparatus of the insane. According to their clinical frequency we meet with, 1st, atrophy; 2d, tremors; 3d, contractures; 4th, spasms; 5th, cramps; 6th, pareses and paralyses. These catagories apply to the voluntary muscular system. Atrophy is very much more frequent in insanity than is commonly supposed, and sometimes reaches excessive grades. It often takes place very rapidly, as in acute delirium. In the various toxic insanities atrophy is commonly the result of trophic lesions in the central nervous system. In the diathetic insanities gout, rheumatism, syphilis, tuberculosis, etcetera—muscular wasting is not infrequent. In general paresis and alcoholic dementia, polyneuritis often induces atrophy. In idiocy, imbecility and cretinism this symptom is common. Simple atrophy may, of course, also arise from disuse as in bed-ridden cases.

Tremors of various kinds, coarse and fine, partial and general, constant and interrupted, or "intentional," are very frequent among the insane. During repose they usually disappear.

Contractures of varying degree are common in insanity. They may be the result of habit, such as fixed postures, for instance in melancholia, or be due to central nervous lesions, as in organic dementia, syphilitic and alcoholic insanity and other forms, or be caused by joint troubles, as in rheumatic insanity.

Spasms, both tonic and chronic, are frequently encountered, but the latter are not as common as the former. Often they resemble, or are identical with, the psychic and convulsive tics. Tonic spasm of the orbicularis palpelbrarum, and of the sterno-cleido-mastoid and trapezius is common. Œsophageal and pharyngeal spasms also occur. The